Healthy Families Program Benefit Options

Final Project Report

Prepared for the Managed Risk Medical Insurance Board

by Kelch Associates

In consultation with Mercer Government Human Services Consulting

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About the Project Consultants

Kelch Associates

Deborah Reidy Kelch, M.P.P.A. is an independent consultant, health policy researcher, and president of Kelch Associates. Kelch Associates provides consulting services to nonprofit organizations, including health policy research and strategic advice, grant writing, organizational development, meeting facilitation, and strategic planning. Deborah returned to independent consulting in 2009 after four years as health policy consultant to the California Assembly Health Committee, most recently as the Chief Consultant and lead policy expert for the Committee. Prior to establishing Kelch Associates in 1995, Deborah served for nearly a decade as policy and fiscal staff to the California Legislature.

Jayne Chaffin, M.P.H., a consulting associate with Kelch Associates for this project, is an independent consultant with more than 20 years of operational and program development experience with health care organizations, including managed health care, hospitals, medical groups and government programs.

Mercer

Mercer Government Human Services Consulting (GHSC) is a specialty consulting group within Mercer Health and Benefits LLC. Mercer GHSC is solely focused on consulting to government sponsored health and benefits programs and has 25 years of experience working with more than 30 state Medicaid and Children's Health Insurance Programs, as well as the federal Centers for Medicare and Medicaid Services. The Mercer GHSC staff includes actuaries, CPAs, nurses, pharmacists, statisticians, and policy experts with national and California-specific experience.

About the Foundation

California HealthCare Foundation

This project was funded by the California HealthCare Foundation, an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, CHCF's goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Project Description

The California HealthCare Foundation (CHCF) contracted with Kelch Associates and Mercer Government Human Services Consulting (Mercer) to conduct an analysis of the benefit design options for California's Healthy Families Program (HFP), California's Children's Health Insurance Program (CHIP) program, which provides low-cost, comprehensive health care coverage for low- and moderate income children in California. This report explores the benefit design options that might be considered for HFP and includes policy and actuarial analyses of selected benefit options, as requested by the Managed Risk Medical Insurance Board (MRMIB), which administers HFP.

This report includes benefit design options under federal law, benefit choices made by other states, and comparison of existing HFP benefits with the specific benchmark plans permitted under federal law. Following discussion and direction from MRMIB at the March 17, 2010 Board meeting, Kelch Associates and Mercer focused on specific benefit design options and program changes for additional analyses and research, including an analysis by Mercer on the potential for program cost-savings from each option.

Project Scope

Federal law authorizes states to provide CHIP, (no longer SCHIP) coverage through the state's Medicaid program or through a separate state program, or a combination of both, using one of several benefit design options outlined in federal law and regulations. Since the inception of California's CHIP program, HFP coverage and benefits have been provided through a separate CHIP program modeled on the State employees benefit package provided through the California Public Employees Retirement System (CalPERS).

The MRMIB Board of Directors and staff requested Kelch Associates to explore benefit and cost-sharing options allowable under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 that might result in HFP program savings. After consultation with MRMIB staff, the scope of the project was limited to HFP medical benefits, excluding review of benefit options for dental and vision coverage.

The purpose of this project was to investigate and assess alternative benefit design options for HFP to better inform the continuing discussions about potential HFP cost reductions in the context of state budget shortfalls. Specifically, the project scope included:

1. Development of a framework for California to assess various HFP benefit options;

2. Identification and assessment of potential options available in federal law with respect to benefit design, family cost-sharing, and other potentially viable cost reductions in any benefit areas;

3. Research and identification of experiences from other states that have used the "Secretary-approved" benefit options and lessons for California, if any; and,

4. Identification of selected benefit design options and program changes for actuarial and cost analysis to develop estimates of HFP cost-savings.

Impact of Federal Health Reform

While this project was underway, Congress passed and the President signed H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), sweeping federal reform of health care. The federal reforms include changes to the CHIP and Medicaid programs, to be implemented over several years, culminating in major program expansions in 2014. Given the overlapping timeframe, and the continuing uncertainty regarding many elements of PPACA, this project was not able to incorporate the impact of specific elements of health care reform on HFP.

One impact of federal reform which passed after the March 17 MRMIB meeting, a federal prohibition of lifetime benefit caps in private coverage, prompted Mercer to eliminate from final analytical review the option of a lifetime benefit limit in HFP. While federal guidance is still pending, and it is unclear whether the ban on lifetime benefit limits and unreasonable annual limits in PPACA applies to CHIP programs, Mercer determined it did not make sense to price such limits until further guidance from CMS is available.

Project Context

At the May 27, 2010 MRMIB meeting, the Board in its final review of the project findings noted that the passage of federal health reform changed the context for evaluation of cost savings in CHIP programs, particularly because federal reform limited state options for making program cuts, and imposed state maintenance of effort requirements in both CHIP and Medicaid. While MRMIB decided not to take any action related to the findings of this project at this time, this analysis can provide background and future guidance to the Board and to policymakers examining the options for program savings in HFP.

Summary of Project Findings and Analyses

This section provides a high level overview of the major project findings in this report.

- States that elect to operate separate CHIP programs have a variety of benefit design options under federal law. There are 40 states with separate CHIP programs covering at least some portion of CHIP-eligible children for comparison purposes with HFP. Among separate CHIP programs, most of the benchmark CHIP plans cover benefits that are similar to the state employee health plan, and most secretary-approved plans are modeled after Medicaid.

- As one option, states may offer benchmark coverage in CHIP that mirrors benefits in the state employee plan, the federal employee plan or the HMO in the state with the largest commercial enrollment. Other than differences in subscriber cost sharing, HFP covered benefits are substantially similar to the benefits covered in the three benchmark benefit plans. Changes to HFP based on the minor benefit differences are unlikely to yield significant cost savings.

- Mercer's actuarial analysis found that HFP coverage is more generous than any one of the three benchmark plan options allowed under federal law. However, the actuarial differences are primarily due to significantly lower subscriber cost sharing in HFP. California could not mirror

the cost sharing in the benchmark plans because of the federal CHIP limit on cost sharing to no more than 5% of subscriber income annually.

- Regardless of the benchmark plan selected by states, few states actually adopt completely a benchmark coverage option because federal limits on cost sharing for CHIP programs are lower than the typical cost sharing in the public or private coverage models. CHIP programs generally adopt the benefits but not the cost sharing of the benchmark plan chosen.

- Comparing HFP to the benchmark plans on an actuarial basis shows that California could reduce the benefits covered in HFP and still meet the federal standards for actuarial equivalence.

- While reductions or elimination of benefit categories from HFP might meet federal actuarial equivalence standards, reducing benefits could require changes to state law to exempt HFP contracting plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) from the requirement to cover basic benefits as defined.

- At MRMIB's request, Mercer modeled a potential HFP benefit limited to the minimum benefits required to be offered in federal law. Mercer found that eliminating home health (including hospice), durable medical equipment and supplies, physical, occupational and speech therapy could yield HFP savings of approximately 1.1%, for an estimated savings of $3.9 million General Fund (based on the November 2009 HFP estimate). Elimination of home health and therapy services would require a state law change for most participating health plans which are licensed under Knox-Keene.

- While HFP savings may be achieved through elimination of entire benefit categories, HFP savings may also be found from the imposition of benefit limits or exclusions, such as limits on hospital coverage or annual or lifetime benefit caps.

- Benefit reductions most likely to achieve real cost savings include limits on hospital and professional services (number of days or visits per year), pharmacy (number of prescriptions) or annual or lifetime benefit limits. It is unclear as of this writing, however, whether benefit reductions in HFP would be prohibited under the maintenance of effort requirements for CHIP and Medicaid programs enacted as part of federal health reform.

- Mercer modeled annual benefit caps for HFP of $200,000 and $50,000 and estimates potential savings of 0.0-2.0% for a $200,000 annual cap and .5-2.5% for a $50,000 annual cap for HFP only. A 2.0% savings translates to a $7 million General Fund savings based on the November 2009 HFP estimate. Mercer did not model a lifetime benefit cap since such limits are prohibited under the federal health reform legislation passed during the course of this project.

- HFP cost sharing is subject to the federal CHIP limit of 5% of family income. Proposals to increase cost sharing must be evaluated to determine whether any families are likely to exceed the federal cap. Family cost sharing in HFP was increased twice in 2009, in February and

November. The Governor has proposed additional premium and copayment increases in the May Revision for 2010-11.

- Mercer found that there is some room to impose additional cost sharing in HFP without exceeding the federal 5% out-of-pocket limit. As an illustration of the results, Mercer estimates that current HFP cost sharing, including monthly premiums, copayment maximums and historical dental and vision copayments for Category B subscribers (families 150-200% FPL) would likely result in maximum cost sharing of approximately 3.16% of family income for families with two children enrolled in HFP. Mercer estimated the same family could have cost sharing as high as 4.38% of income under the cost sharing increases proposed in the Governor's January 2010-11 Budget.

- Mercer also estimated potential state savings resulting from increasing HFP copayments for physician services from $10 to $15 for Category B and C subscribers. Taking into account potential cost increases in emergency room and inpatient services resulting from decreased use of primary care physician visits, Mercer estimated potential net HFP savings of 2.0-3.0%. At 2.5% savings, General Fund savings would be $15.3 million on an annual basis.

- Mercer's review of the pharmacy benefit management strategies of the largest HFP contracting health plans (representing 70% of HFP enrollees) found that HFP contracted health plans retain relatively aggressive pharmacy pricing. Contracting plans reported that they are using a preferred drug list or formulary and 74-83% of pharmacy utilization is for generic drugs. Mercer concluded that there does not appear to be room for significant savings related to the HFP pharmacy benefit.

Background

HFP is California's state and federally-funded CHIP program established pursuant to Title XXI of the federal Social Security Act. MRMIB administers HFP which provides comprehensive health, dental and vision insurance to low-income children under age 19 with family incomes above the Medi-Cal income eligibility levels. Approximately two-thirds of the funding for HFP is provided by federal CHIP and one-third is state funding. HFP provides services to eligible children through public and private health plans for a fixed payment amount each month. As of March 2010, there were 875,081 children enrolled in HFP.

Under federal law, states can either adopt a Medicaid expansion program, a separate CHIP program or a combination of the two. Separate CHIP programs are not entitlement programs like Medicaid and states can take steps to stay within the funds available as outlined in federal law. California operates a combination CHIP program. Under California's combination coverage approach, some children eligible for CHIP coverage are covered through California's Medicaid program (Medi-Cal) and HFP is California's separate program for children in families with incomes of up to 250% federal poverty level (FPL) who are not otherwise eligible for Medi-Cal.

MRMIB is required by statute to maintain enrollment and expenditures to ensure that expenditures do not exceed the amounts available for HFP. If sufficient funds are not available to cover the estimated cost of program expenditures, according to MRMIB regulations, the Board must institute appropriate measures to limit enrollment and establish a waiting list for new applicants. If the Board finds that the waiting list does not sufficiently limit expenditures, children must be disenrolled at the time of their Annual Eligibility Review.

MRMIB contracts for HFP medical care services with 24 public and private health plans, most of whom are licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene). HFP contracting health plans may offer certain optional benefits without additional payments from the State, including acupuncture, chiropractic, and/or biofeedback.

HFP and the State Budget Crises

In the past several years, HFP has been repeatedly slated for program and funding cutbacks, along with many other health and social service programs, as California continues to face sustained and massive budget deficits. In 2009-10, the Governor proposed elimination of HFP. The Legislature rejected the Governor's proposal to eliminate HFP but reduced funding by $124 million General Fund (GF), necessitating implementation of a waiting list for HFP enrollment. The Governor vetoed another $50 million (GF) from the program which created a total funding gap of about $174 million GF.

A temporary solution was enacted in AB 1422 (Bass), Chapter 157, Statutes of 2009, which included the following:

1) Authority for the First 5 California Children and Families Commission (First 5) to transfer funding for coverage of HFP children ages 0-5 (First 5 acted to allocate up to $81.4 million to HFP for this purpose);

2) $157 million from gross premiums taxes imposed on Medi-Cal managed care plans, which yielded $291 million in additional federal funds for HFP; and

3) Increased HFP family premiums and authorized MRMIB to make additional changes to health, dental and vision benefits (MRMIB subsequently increased HFP copayments and revised dental benefit plan choices.)

In January 2010, the Governor proposed to eliminate HFP coverage for families with incomes between 200-250% FPL, a proposal which would most likely violate PPACA, the subsequently enacted federal health care reform bill, because it imposes specific CHIP maintenance of effort requirements on states. In the recently released May revision of the Governor's proposed 2010-11 budget, the Governor restored funding for children with incomes between 200-250% FPL and proposed, starting September 1, 2010, to increase HFP monthly premiums in families with incomes from 200-250% FPL by $18 per child, or $54 maximum per family with 3 or more children. The Governor's May proposal would increase the current HFP premium of $24 per child to $42, and the family maximum from $72 to $126. In addition, the May Revision proposes HFP savings resulting from increasing emergency room copayments from $15 to $50 and adding hospital inpatient copayments of $100 per day up to a maximum of $200.

Federal CHIP Requirements

Under current CHIP federal law and regulation, state options for coverage in a separate CHIP program are as follows:

1. Benchmark coverage, as defined;
2. Benchmark-equivalent coverage, as defined;
3. Existing comprehensive state-based coverage options as grandfathered for Florida, New York and Pennsylvania; or
4. Secretary-approved coverage that is one of several options outlined in federal law and regulations.

Under Medicaid, states are federally mandated to cover certain benefits, including the Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit. Under EPSDT, regular health, dental, hearing and vision screenings must be covered, as well as any medical services that a child is found to need, as long as it is the type of services that Medicaid covers. Under CHIP, states with stand-alone CHIP programs are not required to cover EPSDT and have more flexibility over the benefits package for children.

All CHIP programs are required to provide the following minimum benefits regardless of the benefit design a state chooses:

1. Well-baby and well-child care services as defined by the state;
2. Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and,
3. Emergency services needed to evaluate, treat, or stabilize an emergency medical condition.

Benchmark Coverage

Federal law defines benchmark coverage as coverage consistent with any of the following:

1. Federal Employees Health Benefit Plan (FEHBP) -- The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is offered to federal employees;
2. State employees plan -- Coverage offered and generally available to state employees in the state; or,
3. A health maintenance organization (HMO) plan -- A health insurance coverage plan in the state offered through an HMO which has the largest insured, commercial non-Medicaid enrollment in the state.

Benchmark-equivalent Coverage

Under federal law, benchmark equivalent coverage is health benefits coverage that has an aggregate actuarial value at least actuarially equivalent to the coverage under one of the benchmark packages listed above. Benchmark-equivalent coverage must meet the following federal requirements:

1. Be determined to be actuarially equivalent to one of the three products available as a benchmark option, (plan options listed above) supported by an actuarial opinion the state must provide to the federal Centers for Medicare and Medicaid Services (CMS);

2. Include at a minimum, the minimum benefits required in all CHIP programs as above (well-baby and well-child visits, immunizations and emergency care) plus the following additional categories of services:

    a. Inpatient and outpatient hospital services;
    b. Physicians' surgical and medical services; and,
    c. Laboratory and x-ray services.

3. If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent coverage package includes coverage for prescription drugs, mental health services, vision services or hearing services, then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75% of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

Secretary-approved Coverage

Under federal law, states may apply for approval to the Secretary of the federal Department of Health and Human Services to offer CHIP coverage that meets specified requirements in federal law and regulation. Secretary-approved coverage can be consistent with any of the following benefit options:

1. Coverage the same as the benefits offered in the Medicaid State plan;

2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration;

3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population;

4. Coverage that includes benchmark coverage plus additional coverage;

5. Coverage that is the same as defined by the grandfathered existing comprehensive state-based coverage offered in Florida, New York and Pennsylvania ;

6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison; and,

7. Other.

CHIPRA Benefit Changes

The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 extends and expands the State Children’s Health Insurance Program. CHIPRA made the following benefit changes to CHIP:

1. *Dental* -- Requires states to include dental services (meeting new statutory standards or equivalent to one of three dental benchmark packages) in CHIP plans. In addition, CHIPRA would allow states the option to provide dental-only supplemental coverage for children who otherwise qualify for a state's CHIP program, but have other health insurance without dental benefits; and,

2. *Mental Health* -- Requires mental health parity for states that select a benchmark plan that includes coverage for mental health or substance abuse services. According to CMS, CHIPRA requires that state child health plans comply with the mental health parity requirements included in the Public Health Services Act "in the same manner" as such requirements apply to a group health plan.[1] Specifically, the mental health parity changes require the following coverage for mental health:

    a. Financial requirements (e.g., copayments) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits;

    b. Treatment limitations (e.g., numbers of visits or days of coverage) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits;

    c. No separate financial requirements or treatment limitations can apply only to mental health or substance use disorder benefits; and,

    d. When out-of-network coverage is available for medical/surgical benefits, it also must be available for mental health or substance use disorder benefits.

Federal CHIP Cost Sharing Limits

Federal CHIP law permits states to impose cost-sharing for some beneficiaries and some services.[2] States that cover low income children through a Medicaid expansion must follow Medicaid rules for nominal cost-sharing and rules specific to CHIP Medicaid expansion programs pursuant to the Deficit Reduction Act of 2005.

States with separate CHIP programs may charge premiums or enrollment fees within the maximum total limit imposed. For all individuals enrolled in CHIP, the total aggregate amount of all cost-sharing cannot exceed 5% of family income (on a quarterly or monthly basis as specified by the state). Enrollees may also be charged service-related cost-sharing, but such cost-sharing is limited to: (1) nominal amounts defined in federal Medicaid regulations for the subgroup with income below 100% FPL, and (2) slightly higher amounts defined in CHIP regulations for families with income between 100%-150% FPL, including no more than $5 per visit for services provided by a managed care organization, except that the copayment for non-emergency use of the emergency room can be up to twice the basic copayment, or no more than $10.[3] For a family with income above 150% FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-

income children, and subject to the out-of-pocket limit of 5% of family income.[4] Preventive services, as defined by CMS, are exempt from any cost-sharing for all CHIP enrollees regardless of income.

Project Analyses and Findings

This project was conducted in two phases. In Phase 1, Kelch Associates and Mercer partnered on preliminary analyses of potential benefit options and cost savings for presentation to the MRMIB. Kelch Associates researched the benefit options in federal law and identified what many other states have done in developing CHIP benefit designs. Kelch Associates compared HFP benefits with the three benchmark options in California, and Mercer conducted an actuarial equivalence analysis on the benchmark plans. Kelch Associates and Mercer identified potential options for further analysis and presented those findings to the MRMIB on March 17, 2010 seeking further guidance from the Board.

At the March 17 meeting, MRMIB requested further analysis of the potential for cost savings associated with the following program and benefit changes and options:

1. Reducing HFP benefits to benchmark-equivalent coverage with the minimum benefits required by federal CHIP law;
2. Imposing annual and lifetime benefit limits in HFP (similar to limits imposed in Wyoming);
3. Coverage with service limits (e.g., limits on the number of hospital days per year), to the extent similar limits were imposed in other states;
4. Potential HFP pharmacy cost savings based on a review of HFP health plan pharmacy benefit management strategies; and,
5. Calculation of the cost savings associated with imposing increased cost sharing in HFP that would still fall below the annual out-of-pocket limit of 5% of family income in federal CHIP law.

In Phase 2, Kelch Associates worked with Mercer to further refine the options and Mercer conducted actuarial and fiscal analyses on the specific options as requested by the MRMIB.

Project Phase I: Identifying Benefit Options for HFP

During the first phase of the project, Kelch Associates researched and outlined the various benefit options for CHIP programs authorized under federal law, reviewed HFP in the context of those options and researched other state CHIP programs to identify state benefit design choices.

Analysis of Benchmark Coverage Option

Since the inception of HFP in 1997, California has by statute provided health benefits to HFP-enrolled children based on the CalPERS state employee benefit package as benchmark coverage. In addition, HFP children with certain complex medical conditions receive treatment of those conditions through the CCS program.

Kelch Associates consulted with the California Association of Health Plans to identify the HMO plan with the largest commercial enrollment in California. The plan that most likely fits the federal definition is an HMO plan offered by Kaiser Permanente to small employers, with an estimated enrollment of just over 157,000 lives.[5]

Appendix A compares the benefits offered (services covered) and the cost-sharing (copayments, deductibles, etc.) in HFP with the three benchmark coverage options. The comparison is based on a comprehensive review of the Evidence of Coverage (EOC) documents for several of the largest HFP health plans and the possible benchmark plans (e.g. Federal Employees Health Benefits Plan; CalPERS, and Kaiser HMO for small employers). EOCs are the detailed contractual disclosure documents that health plans provide to subscribers and enrollees of a particular benefit plan.

HFP covered health benefits and those offered by the benchmark health benefit plans are substantially similar, with some relatively minor differences. Highlights of benefit differences include:

1. Hearing Services – All benchmark benefit plans appear equal in coverage of routine hearing screenings. However, HFP coverage for hearing testing and examinations for the prescribing or fitting of hearing aids is the broadest coverage of the benefit plans reviewed. CalPERS coverage provides that the primary care/personal physician will provide hearing screening to determine the need for an audiogram for hearing correction, as well as newborn hearing screening services. HFP does not appear to have this restriction, potentially permitting referrals to specialists to conduct hearing screenings.

2. Durable Medical Equipment – HFP appears to have the broadest coverage of DME among the plans reviewed.

3. Mental Health and Alcohol and Drug Abuse Services – Mental health and substance abuse parity will be applicable to HFP at the beginning of the next benefit year, which is scheduled for October 1, 2010. Meantime, the three benchmark benefit designs have already been adjusted for mental health parity and thus have greater coverage for mental health services at present.

4. Home Health Care – The Kaiser small group employer plan and the FEHBP plan have lower home health care coverage and limits on the number of visits covered compared to HFP.

5. Skilled Nursing Care – The FEHBP excludes coverage for skilled nursing, whereas all other benchmarks and HFP cover 100 days of skilled nursing.

Findings:

- ***Other than differences in subscriber cost sharing, HFP covered benefits are substantially similar to the benefits covered in the three benchmark benefit plans with only relatively minor differences identified above.***
- ***Other than cost sharing, changes to HFP based on benefit differences with the three benchmark plans are unlikely to yield significant program savings.***

Analysis of Benchmark Equivalent Option

Benchmark equivalent coverage must meet the federal test of actuarial equivalence to one of the three benchmark plans, and must cover the minimum basic benefits required for all CHIP benefit plans (well-baby/well-child care, immunizations and emergency services) and other specific benefits as discussed

above. Within these limits, states can design any array of CHIP benefits, providing they are determined to be actuarially equivalent according to federal regulatory requirements.

Actuarial equivalence is a general term used to describe two or more benefit designs that have approximately the same value.[6] In this context, "value" may mean several things, but is commonly either the dollar value of average benefits expected to be paid out by a health plan or the average percentage of total health spending that is covered under the policy or plan. Potential plan design differences considered when performing actuarial equivalence comparisons include cost-sharing features, differences in services covered, and major differences in utilization expected to result from differences in cost-sharing.[7] For example, higher cost-sharing can result in lower utilization. Provider network differences are not generally included in actuarial equivalence comparisons and the calculations generally assume the use of in-network services for non-emergency health care.

To initially determine the relative actuarial relationship between HFP and the three benchmark equivalent plans, Mercer conducted an actuarial analysis, the results of which are shown in Table 1 below.

Table 1
Mercer Actuarial Analysis
Comparison of HFP to Benchmark Plans

HFP Premium level	CalPERS	FEHBP	Kaiser HMO for small employers
Category A	1.10	1.33	1.46
Categories B & C	1.06	1.28	1.40

The Mercer findings reveal that HFP coverage (benefits plus cost sharing) is 6-10% richer than CalPERS, 28-33% richer than FEHBP and 40-46% richer than the Kaiser small employer plan used for comparison.

The differences shown in Table 1 are almost entirely attributable to the differences in subscriber cost sharing among the benchmark plans and HFP. For illustration purposes, the cost sharing differences between the Kaiser HMO and HFP are as follows:

- Office visit--$30 copayment for Kaiser and $10 for HFP (Categories B & C);
- Pharmacy--$10 generic copayment/$35 brand copayment for Kaiser (once a $250 brand deductible is met), compared to $10 generic and $15 brand name in HFP (Categories B & C);
- Outpatient services--Kaiser has a $100 emergency room (ER) copayment and a $200 surgery copayment; HFP has a $15 ER copayment (Categories B & C) and no surgery copayment; and,
- Inpatient services--$400 per day copayment for Kaiser and no copayment for HFP.

The Mercer analysis results in Table 1 also mean that California could meet the actuarial equivalence test for any one of the three benchmark benefit plans, even with reductions or elimination of benefits currently covered under HFP. Savings could likely be achieved by reducing HFP benefits and still be in compliance with federal law. The following benefits currently covered by HFP are not mandatory under federal law for benchmark-equivalent coverage:

1. Medical transportation (Knox-Keene basic health care service -- elimination in HFP would require an exemption in law for participating HFP health plans, all but one of which are Knox-Keene licensed plans. Knox-Keene requires coverage of emergency ambulance services as a basic health care service);
2. Physical, occupational and speech therapy (Knox-Keene basic health care service);
3. Family planning (Knox-Keene basic health care service);
4. Health education services (Knox-Keene basic health care service);
5. Durable medical equipment;
6. Skilled nursing services; and,
7. Acupuncture, chiropractic and biofeedback (optional at plan's discretion in HFP and not at state cost).

As noted above, elimination of benefits not mandatory in federal law would require a change in state law to the extent that the benefits eliminated are mandatory basic benefits under Knox-Keene. Knox-Keene basic benefits are:

1. Physician services;
2. Hospital inpatient and ambulatory care services;
3. Diagnostic laboratory and diagnostic and therapeutic radiologic services;
4. Home health services;
5. Preventive health services;
6. Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage and ambulance transport services provided through the "911" emergency response system; and,
7. Hospice care.

Findings:

- ***HFP coverage is more generous than any one of the three benchmark plan options allowed under federal law, but the differences are primarily a function of differences in subscriber cost sharing.***
- ***California could not mirror the cost sharing in the benchmark plans because of the federal CHIP limit on cost sharing to no more than 5% of subscriber income per year.***
- ***Comparing HFP to the benchmark plans on an actuarial basis shows that California could reduce the benefits covered in HFP and still meet the federal standards for actuarial equivalence.***
- ***Reductions or elimination of benefits covered in HFP might meet federal standards, but could require changes to state law to exempt HFP plans from Knox-Keene basic benefit requirements.***
- ***While savings may be found through elimination of entire benefit categories, savings may also be found by imposing benefit limits or exclusions, such as limits on hospital benefits or annual or lifetime benefit caps.***

Benefit and Service Limit Options

Cost-savings for HFP through benefit design changes may not be a matter of cutting entire benefit classes as discussed above, but may instead require imposing limitations and exclusions that might trim costs, along with targeted cost-sharing. According to Mercer, examples of benefit reductions most likely to achieve real cost savings are:

- Limits on hospital services (number of days per year);
- Limits on professional services (number of office visits per year);
- Pharmacy limits (number of prescriptions per month, increased use of generics); or,
- Annual or lifetime benefit limits.

According to the results of a 2008 survey of states conducted by the National Academy for State Health Policy (NASHP),[8] which is forthcoming, very few state CHIP programs impose benefit limits such as caps on the number of covered hospital visits or specific numbers of physician office visits. Most states with such limits at the time of the NASHP survey applied the limits (i.e., 30 days hospital coverage) to coverage for mental health conditions; limits likely to be revised to comply with the recent CHIPRA requirements to apply mental health parity to CHIP programs. Pennsylvania reported a 90-day total hospital inpatient limit per year applicable to both medical and mental health conditions.

Few states impose annual or lifetime benefit limits in CHIP programs, but Wyoming imposes an annual benefit of $200,000 and lifetime limit of $1 million.

Findings:

- ***The potential for HFP cost savings may not be limited to elimination of entire benefit classes but may also be achieved through benefit and service limitations or caps.***

- ***Benefit reductions most likely to achieve real cost savings include limits on hospital and professional services (number of days or visits per year), pharmacy (number of prescriptions), or annual or lifetime benefit limits.***

Pharmacy Benefit Options

The cost of providing pharmacy benefits has risen significantly during the last decade, surpassing the cost increases experienced by employers for any other category of medical services.[9] As a consequence, most health plans have some clinical/formulary management programs.[10] Most HMOs exert considerable control over pharmacy utilization through both provider education and plan design, including the use of formularies. HFP is providing services through licensed health plans and the ability to achieve pharmacy savings will depend on the extent to which HFP health plans implement pharmacy cost controls.

Pharmacy benefit changes that might be considered to reduce program costs in HFP include:

- Establishment of a carve-out for pharmacy services that relies on a single program-wide pharmacy benefit manager (PBM) to manage and pay claims for prescription drugs;
- Utilization of program-wide drug formularies as are used in the Medi-Cal program;
- Differential coverage and copayments for generic and brand-name prescriptions;
- Negotiation of rebates from pharmaceutical companies;
- Implementation of utilization controls, such as prior authorization and fail-first or step therapy requirements; and,
- Implementation of or more aggressive Maximum Allowable Cost (MAC) pricing for ingredient costs (primarily for generic or multi-source brand drugs).

In evaluating the cost-savings potential of various pharmacy benefit changes in HFP, Mercer worked with MRMIB staff to identify the pharmacy cost controls already implemented by the contracting HFP health plans.

Findings:

- ***Pharmacy benefit changes that might reduce pharmacy expenditures in HFP include carving out the entire pharmacy benefit for management by a separate benefit manager, utilization controls and drug formularies, differential cost sharing for generic and brand name drugs and aggressive purchasing strategies.***
- ***The ability to find HFP cost savings from pharmacy benefit changes will depend on the extent to which HFP participating health plans already employ cost controls and the effectiveness of those pharmacy benefit management tools. In Phase II, Mercer evaluated the current pharmacy benefit management practices of HFP health plans.***

Cost-sharing Options

In the current HFP, monthly family premiums are determined based on family size, family income as a percentage of the federal poverty level (FPL) and health plan selected. Current premiums are set at $4 to $14 per family for those at 150% of FPL and below (premium Category A); $13 to $48 per family for those at 150-200% FPL (premium Category B); and $21 to $72 per family for those at 201-250% FPL (premium Category C). HFP family cost sharing was increased twice in 2009. Effective November 1, 2009, copayments for families in premium categories B and C were increased as follows:

- Copayments for non-preventive health, dental, and vision services increased from $5 to $10 per visit;
- Copayments for generic prescription drugs increased from $5 to $10 per script;
- Copayments for brand name prescription drugs increased from $5 to $15 per script, unless no generic is available or the brand name drug is medically necessary ($10); and,
- Copayments for emergency room services increased from $5 to $15 per visit, unless the child has to stay in the hospital which will result in waiver of the copayment.

Copayments for families in Premium Category A remain unchanged at $5 per copayment for services. In January 2010, the Governor proposed to eliminate eligibility for HFP entirely for children in families with incomes of 200-250% FPL and to increase premiums for families with incomes of 150-200% FPL to $30 for one child; $60 for two; and a family maximum of $90 for three or more. The Governor's January proposed premium increases would have put HFP premiums at the higher end of premiums charged compared to other states. The 2010-11 May Revision also proposes to increase HFP monthly premiums and to impose higher cost sharing for emergency room and hospital inpatient services.

To determine the maximum amount of premiums and copayments that can be charged under the federal law, Mercer worked with MRMIB staff to review previous staff calculations and to assist in determining the level of both premiums and copayments that may be imposed under the 5% of income overall family limit in federal law.

Given the relatively low level of subscriber cost sharing in HFP to date, including the $250 annual cap on total health plan copayments, California has never had to calculate and disclose to each enrolled family on an annual basis the specific dollar level of their maximum cost-sharing, including premiums and copayments. To the extent that higher cost sharing in HFP increases the potential for families to reach or exceed the federal 5% cap, California may have to implement such a methodology. The additional requirements could increase administrative costs for the program and for contracting health plans and could underestimate the savings from the increased cost sharing.

Findings:

- ***Family cost sharing in HFP was increased effective November 1, 2009 and the Governor has proposed further cost sharing increases in the May Revision for 2010-11.***
- ***HFP cost sharing is subject to the federal CHIP limit of 5% of family income and must be evaluated to determine whether any families are likely to exceed the federal cap under specific cost-sharing proposals.***

Phase II: Mercer Analyses of Selected Options

At the March 17 MRMIB meeting, the Board requested further analysis of the following benefit and cost savings options in HFP:

1. Minimum Benchmark Equivalence for HFP;
2. Implementation of annual and lifetime benefit maximums on HFP coverage as imposed in Wyoming;
3. Benefit and service limits as alternative benefit designs, to the extent other states have implemented such limits;
4. Cost-sharing options available under the CHIP 5% of income threshold; and
5. Potential cost savings related to prescription services.

This section outlines the results of Mercer's analysis of the options above.

Data sources

Unfortunately, no HFP-specific encounter data is available for detailed cost analyses of program expenditures. The HFP rate development template (RDT) information is reported by HFP-contracted health plans only at a high level and it is difficult to draw many conclusions from that data. Therefore, Mercer also utilized a variety of other data sources to perform the analyses related to this project.

Mercer utilized the following data sources: Medi-Cal encounter and fee-for-service (FFS) data, HFP RDT financial data, and Mercer's proprietary commercial database specific to the Southwest region. The Medi-Cal data and the proprietary commercial database are comprised of detailed claims-level data and/or data summaries. Mercer selected the Medi-Cal data (lower income children) and the commercial data (higher income children) concluding that it would be likely that HFP experience/results would fall somewhere between these two data sets.

Minimum benchmark equivalence

To identify potential savings, Mercer first identified the major categories of current HFP spending. Table 2 below shows the breakdown of spending in HFP by medical service.

Table 2
Current HFP Spending by Service Category
Estimated 2010-11

Service	Percent of Medical Costs
Inpatient	**9.5%**
Outpatient facility/ER	**23.5%**
Physician	**51.2%**
Rx	**10.7%**
Lab/radiology	**1.2%**
Other	**3.9%**
Total	**100.0%**

Source: Mercer, based on HFP health plan data reported to MRMIB in the rate development templates (RDTs)

MRMIB requested that Mercer analyze a minimum benchmark equivalence plan, or one that covers the minimum services required in federal law, specifically:

1. Inpatient and outpatient services;
2. Physicians' surgical and medical services;
3. Laboratory and x-ray services;
4. Well-baby and well-child services;
5. Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP);
6. Emergency services needed to evaluate, treat or stabilize an emergency medical condition; and,
7. Since all three benchmark plans in California provide coverage for prescription drugs, mental health services, vision services or hearing services, then HFP must include coverage for those services that is at least 75% of the actuarial value of the coverage in the benchmark selected.

HFP currently covers five service categories that are not specifically required in federal law and which Mercer determined would have some potential for cost savings if eliminated: home health, including hospice; durable medical equipment and supplies; physical and occupational therapy; and speech therapy. As shown in Table 3, based on the November 2009 estimate of 2010-11 expenditures, eliminating HFP coverage for the five services would reduce the total medical HFP managed care capitation rate (excluding CCS, mental health, vision and dental) by 1.1%, and translate to a savings of approximately $11.0 million total funds on an annual basis, or $3.9 million General Fund.

Importantly, elimination of home health, and physical, occupational and speech therapy would require a statutory exemption from the mandatory Knox-Keene basic benefits for HFP health plans licensed under Knox-Keene.

Table 3
Estimated Savings from Elimination of HFP Benefits
Not Required under Federal Law, by Service Category

Service	% of Medical Capitation
Home Health (including Hospice)	**0.0%**
DME & Supplies	**0.4%**
Physical & Occupational Therapy	**0.3%**
Speech Therapy	**0.4%**
Total	**1.1%**

Source: Mercer based on data from the HFP contracted health plan RDTs for 2010-11

Annual or lifetime benefit maximum

MRMIB also requested an analysis of the potential impact of annual and lifetime benefit maximums in HFP. The recently enacted federal health care reform bill, PPACA, prohibits lifetime benefit limits and "unreasonable annual limits." As of this writing, it is not known if these federal prohibitions will be

applicable in CHIP and there is no definition or guidance as to what would constitute an "unreasonable" annual limit. Kelch Associates found that Wyoming currently has a $200,000 annual limit and a $1 million lifetime limit on their CHIP program benefits.

Mercer analyzed potential HFP savings using a $200,000 annual benefit limit, as well as a $50,000 annual limit for illustrative purposes. Also, since CCS is carved out of the HFP program, Mercer did the analysis both including and excluding these services to show the dramatic impact that these services have on the calculation. Mercer did not include vision, dental and mental health services in this analysis, and does not believe the costs for those services would have a material impact on the results. Table 4 shows the results of the Mercer analysis. For illustration, savings of 0-2% in HFP translates to approximately $20.0 million savings in total funds, $7 million General Fund.

Table 4
Estimated HFP Savings as a Percent of Medical Annual Benefit Caps

Annual Benefit Limit	Range of Potential Savings – Including CCS	Range of Potential Savings – Excluding CCS
$200,000	-0.5% to -2.5%	0.0% to -2.0%
$50,000	-5.0% to -7.0%	-0.5% to -2.5%

Source: Mercer based on data in the HFP contracted health plan RDTs for 2010-11

As indicated in Table 4, an annual benefit limit of $50,000 implemented only for non-CCS services would have a maximum potential cost savings benefit of up to 2.5% of HFP medical capitation payments. A $50,000 annual benefit maximum that includes CCS services could potentially save up to 7.0%; however, that would be at a $50,000 annual limit level. Implementation of an annual benefit limit would require further discussion with CMS as to allowable annual limits in CHIP, if any. Annual benefit limits would also require statutory changes for participating Knox-Keene health plans that are required to cover all medically necessary basic health care services.

Benefit Designs with Service Limits

Mercer identified service-specific dollar or utilization limits as an option to achieve cost savings in HFP. Examples of such limits would include a 30-day inpatient annual limit or a four scripts per month prescription limit. Benefit coverage limits such as these may meet federal law requirements if they were implemented as a Secretary-approved coverage option.

MRMIB requested an analysis of service limits, only to the extent that such a benefit design is utilized by another state or states.

According to the NASHP survey, very few state CHIP programs impose benefit limits such as limits on the number of covered hospital visits or specific numbers of physician office visits. States that had such limits at the time of the NASHP state survey applied the limits (i.e., 30 days hospital coverage) to coverage for mental health conditions; limits likely to be prohibited by the recent CHIPRA application of mental health parity to CHIP programs. Pennsylvania reported a 90-day total inpatient limit per year applicable to both medical and mental health conditions. Mercer indicated that a benefit limit that applied to medical and mental health would be difficult to model given the data limitations and hospital limits in particular may not likely result in significant savings in HFP, given that inpatient services represents less than 10% of HFP medical costs as illustrated in Table 1 on page 13.

In addition, it is unclear whether imposing these types of limits would comply with the CHIP maintenance of effort requirements contained within PPACA, the federal health care reform bill.

This project did not model benefit service limits because the only state with such limits (PA) applied the benefit limitation in a manner that would have been difficult to model for potential HFP cost savings given HFP data limitations.

Cost sharing and the 5% CHIP threshold

There are essentially two different cost-sharing levers that could contribute to HFP cost savings. The first is member premiums. According to Mercer, premiums should be set so that the member shares in the financial responsibility of obtaining health coverage, but they must also be affordable to the member. Increasing member premiums could potentially drive away healthier members. Low income beneficiaries are very price sensitive and if a child doesn't use many services, a parent may decide that the money could be better spent elsewhere. If healthy children leave the program, the number of enrollees will decrease, but the average risk/cost of the remaining children would increase since the higher risk members will still find it economical to maintain coverage.

The second option for cost sharing is copayments. Healthier children may be more willing to stay enrolled if copayments are increased since they don't use many services anyway, and the increase will only minimally impact them. However, for the higher utilizers, an increase to copayments could become unaffordable, forcing this group to forgo some necessary services. While this would result in a lower average net cost per service and lower utilization of physician and related services, it will likely result in some level of increased hospital and emergency room (ER) costs, which would reduce to some degree utilization and unit cost savings.

HFP copayments were increased twice in 2009 and the Governor proposed additional increases in the May Revision for 2010-11. It should also be noted that while federal law provides flexibility in establishing copayments for eligibility groups above 150% FPL, there are restrictions for the level of copayments that can be imposed on eligibility groups below 150% of FPL. In addition, copayments do not apply to preventive services such as well-child visits.

Mercer suggests that a balance must be achieved between cost sharing, affordability and the goals of the HFP program.

Table 5 and 6 below show the calculation of the current HFP cost-sharing percentage for both Category B and Category C HFP enrollees. The analysis of cost sharing was developed by MRMIB staff and reviewed by Mercer which confirmed the results.

Table 5
Analysis of Current HFP Cost Sharing Percent of Family Income, 2009-10
HFP Enrollees - Category B Subscribers

Family Size	Single Parent Annual Income 150% FPL*	Federal 5% Cost-Sharing Ceiling	HFP Annual Premium $16/month/child $48/mo max	Current HFP Copayment Maximum Per Family	Historical Maximum HFP Dental and Vision Copayments**	Current HFP Cost-Sharing Percent
1 Child	$21,865	$1,093	$192	$250	$235	3.10%
2 Children	$27,481	$1,374	$384	$250	$235	3.16%
3 Children	$33,085	$1,654	$576	$250	$235	3.21%

*Source: Based on Mercer review of MRMIB staff analysis. *Dollar amounts are based on the April 1, 2009 FPL. ** Amounts from HFP OOP Expenditures Report, November 2009.*

Table 6
Analysis of Current HFP Cost Sharing Percent of Family Income, 2009-10
HFP Enrollees - Category C Subscribers

Family Size	Single Parent Annual Income 200% FPL*	Federal 5% Cost-Sharing Ceiling	HFP Annual Premium $24/month/child $72/mo max	Current HFP Copayment Maximum Per Family	Historical Maximum HFP Dental and Vision Copayments**	Current HFP Cost-Sharing Percent
1 Child	$29,149	$1,457	$288	$250	$235	2.65%
2 Children	$36,625	$1,831	$576	$250	$235	2.90%
3 Children	$44,101	$2,205	$864	$250	$235	3.06%

*Source: Based on Mercer review of MRMIB staff analysis. *Dollar amounts are based on the April 1, 2009 FPL. ** Amounts from HFP OOP Expenditures Report, November 2009.*

Since the current level of cost sharing for the Category B and Category C groups is no more than 3.21%, Mercer found there is room to impose additional cost sharing in the HFP program. However, it is unclear as of this writing whether imposing premium increases would comply with the maintenance of effort requirements contained within the federal health reform legislation.

The Governor's January proposed budget would increase the annual premiums for HFP members in categories B and C enrollment groups. Tables 7 and 8 below show the impact the increased premiums would have on the cost sharing calculation.

The analysis reveals that the Governor's proposed premium increases would have pushed the HFP cost-sharing percent up just beyond 4.7%, on an annual basis, for a single parent with three children (category B).

Table 7
Analysis of HFP Cost Sharing Percent of Family Income
Governor's January Budget Proposal, 2010-11
HFP Enrollees - Category B Subscribers

Family Size	Single Parent Annual Income 150% FPL*	Federal 5% Cost-Sharing Ceiling	HFP Annual Premium $30/month/child $90/mo max	Current HFP Copayment Maximum Per Family	Historical Maximum HFP Dental and Vision Copayments**	Current HFP Cost-Sharing Percent
1 Child	$21,865	$1,093	$360	$250	$235	3.86%
2 Children	$27,481	$1,374	$720	$250	$235	4.38%
3 Children	$33,085	$1,654	$1,080	$250	$235	4.73%

*Source: Based on Mercer review of MRMIB staff analysis. *Dollar amounts are based on the April 1, 2009 FPL.*
*** Amounts from HFP OOP Expenditures Report, November 2009.*

Table 8
Analysis of HFP Cost Sharing Percent of Family Income
Governor's January Budget Proposal, 2010-11
HFP Enrollees - Category C Subscribers

Family Size	Single Parent Annual Income 200% FPL*	Federal 5% Cost-Sharing Ceiling	HFP Annual Premium $42/month/child $126/mo max	Current HFP Copayment Maximum Per Family	Historical Maximum HFP Dental and Vision Copayments**	Current HFP Cost-Sharing Percent
1 Child	$29,149	$1,457	$504	$250	$235	3.39%
2 Children	$36,625	$1,831	$1,008	$250	$235	4.08%
3 Children	$44,101	$2,205	$1,512	$250	$235	4.53%

*Source: Based on Mercer review of MRMIB staff analysis. *Dollar amounts are based on the April 1, 2009 FPL.*
*** Amounts from HFP OOP Expenditures Report, November 2009.*

While there is not a lot of room left (if the Governor's January proposal was enacted), Mercer found that some savings may still be achievable by increasing the copayments for physician services from the current $10/visit to $15/visit for categories B and C enrollees. As described earlier, such an increase would likely cause a decrease in physician service utilization, as well as the direct decrease to unit cost.

There would also likely be a resulting increase in ER and inpatient services. Mercer also estimated potential state savings resulting from increasing HFP copayments for physician services from $10 to $15 for categories B and C subscribers. Taking into account potential cost increases in emergency room and inpatient services resulting from decreased use of primary care physician visits, Mercer estimated potential net HFP savings of 2.0-3.0%. At 2.5% savings, General Fund savings would be $5.4 million on an annual basis.

Potential Cost Savings for Prescription Services

Pharmacy expenditures have become a more significant portion of health care costs for virtually all health coverage/programs over the past ten years. Based on the HFP contracted health plan reported data reviewed, pharmacy costs account for approximately $96.0 million total funds, or 10.7% of HFP health care expenditures, and 9.6% of total HFP expenditures, excluding services provided outside of health plan contracts (e.g., CCS, mental health, dental and vision).

Based on this, Mercer estimates that every 10% of savings potential from current pharmacy expenditures could result in approximately 0.96% of total HFP managed care spending. Based on the projected state fiscal year 2010 (SFY 10) expenditures, 0.96% is equal to about $9.6 million total funds, or $3.37 million General Fund.

In light of the recent passage of national health care reform, Mercer considered whether the PPACA offers any opportunities related to CHIP and pharmacy expenditures in particular. While PPACA will provide some potential savings opportunities for Medicaid managed care programs, unfortunately, it does appear to directly offer any new pricing or other benefits for CHIP pharmacy.

In order to assess whether savings opportunities exist related to the HFP pharmacy benefit, Mercer solicited pharmacy pricing and other data from a select group (the largest HFP plans accounting for more than 70% of the membership) of the HFP-contracted health plans. In particular, data was requested and reviewed related to the health plans' dispensing fees and contracted discounts off Average Wholesale Price (AWP) for generic, brand and specialty drugs. In addition, Mercer surveyed the plans to find out whether they were using a formulary/preferred drug list and at what rate they have been dispensing generic drugs.

Based on the data provided by the HFP-contracted health plans, it appears HFP-contracted health plans are obtaining relatively aggressive pharmacy pricing. The plans indicated that they are using a formulary or preferred drug list. In addition, the HFP plans reported generic drug utilization rates of 74 – 83%. This demonstrates that the health plans appear to be doing a good job managing the pharmacy benefits.

While some variation in contract rates shows that there may be some level of savings potential related to pharmacy, Mercer concluded that there is not room for significant savings related to the HFP pharmacy benefit.

CHIP Coverage and Benefits in Other States

This section relies primarily on the 2008 NASHP state survey, and review of the CHIP state plan fact sheets posted on the CMS web site,[11] to provide an overview of state CHIP program benefits.[12]

According to CMS, as of April 23, 2010, six states, five territories and the District of Columbia adopted Medicaid expansions as their CHIP programs, 17 states adopted separate state child health plan coverage, and 27 states, including California, adopted combination programs.[13]

According to NASHP, of the 44 states with at least some portion of the CHIP program provided as a separate program, 4 states (AR, MN, OK, RI) operate separate CHIP programs only for pregnant women under the "unborn" option in the CHIP regulations. This means that there are 40 states with separate CHIP programs covering low-income children for comparison purposes with HFP.

Among separate CHIP programs, most of the benchmark CHIP plans are based on the state employees' health plan, and most secretary-approved plans are modeled after Medicaid.[14] According to the preliminary NASHP survey, and review of state plans, one state, New Hampshire, chose the federal employees FEHBP coverage as the benchmark, 18 states chose the state employee plan and 4 states (AL, CO, IN, and WI) chose the largest commercial HMO plan.

According to the preliminary NASHP survey, no other state has pursued a CHIP program with actuarially equivalent benchmark coverage. However, a review of the state CHIP plans posted on the CMS web site found the following:

- *Indiana* reports offering a benchmark-equivalent which is actuarially-equivalent to benefits in the FEHBP program;
- *Colorado* reports offering a benchmark-equivalent that covers inpatient services; outpatient services; physician services; surgical services; dental services; vision services; prescription drugs; lab and radiology services; prenatal care and family planning services; inpatient and outpatient mental health services; outpatient substance abuse treatment services; durable medical equipment; home and community-based health care; case management services; physical and occupational therapy; hospice care; medical transportation; organ transplant and skilled nursing facility care;
- *Illinois* reports offering a benchmark-equivalent consistent with the state employee plan; and,
- *New Hampshire* reports benchmark-equivalent coverage based on an actuarial analysis comparing the benefit package to the Federal Employees Health Benefit Program. Effective January 1, 1999, a State plan amendment modified the prescription benefit, mental health and substance abuse benefit, and dental benefit. An actuarial analysis submitted to CMS demonstrated that health benefit coverage under the amended Title XXI plan remains benchmark-equivalent; and,
- *Utah* -- Utah offers benchmark-equivalent coverage and includes in the state CHIP plan an actuarial analysis comparing the benefit package to the benefit plan provided to Utah State employees.

Table 9
States with Separate CHIP Programs

Federal Benefit Option Offered NASHP 2008 Survey of State CHIP Programs	
Type of plan	**States**
Benchmark -- State employee plan	CA, CT, DE, IA, IL, LA, MI, MS, MT,NJ, NC, ND, SC, TN, UT, VA, WV
Benchmark -- FEHBP	NH
Benchmark -- Commercial HMO	AL, CO, IN, WI
Benchmark-equivalent	Several states answered the NASHP survey as having a benchmark equivalent plan or Secretary-approved plan, but further described the plan as based on a benchmark option (e.g., state employee plan). Those states are recorded in the respective benchmark category above.
Secretary-approved (same as Medicaid)	AZ, FL, GA, KS, KY, ME, MA, MO, NV, SD, VA, VT, WA
Secretary- approved (grandfathered)	FL, NY, PA
Secretary-approved (Other)	MA, OR, TX, WY
Source: Kelch Associates, based on NASHP survey data and review of state CHIP plans filed on the CMS Internet Web Site for states that did not respond to the NASHP survey. Some states offer more than one qualifying benefit design.	

Secretary-approved Coverage

Under federal law, states may apply for approval to the Secretary of the federal Department of Health and Human Services to offer CHIP coverage that meets specified requirements in federal law and regulation. Nearly half of the states with "Secretary-approved" coverage are providing the state's Medicaid benefits in the separate CHIP programs. Five states have "other" Secretary-approved coverage, but generally speaking the benefits in those programs have features unique to the individual state.

Secretary-approved coverage can be consistent with any of the following benefit options:

1. Coverage the same as the benefits offered in the Medicaid State plan -- According to NASHP, 17 states have been given approval to use the state's Medicaid benefits for the separate CHIP programs, and observers generally agree that it is the policy of CMS to approve proposals to use the Medicaid state plan benefits to define CHIP coverage. This benefit option would include the provision of the full EPSDT benefit for children;

2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project -- Massachusetts covers some CHIP-eligible children with the basic benefits package developed for the state's current Section 1115 health care reform waiver.

3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population -- There is no evidence of a state seeking or receiving approval to offer CHIP coverage pursuant to this option;

4. Coverage that includes benchmark coverage plus additional coverage -- Georgia offers a "Secretary-approved" plan meeting this description. The GA BlueChoice Health Care Plan, the state's HMO with the largest enrollment, is the benchmark plan. The benefit plan for GA PeachCare for Kids is the benchmark coverage with added services to bring the coverage to equal a Medicaid look-alike, with the exceptions of non-emergency transportation, targeted case management, services solely for persons over age 19, and some services that to be needed require a level of disability that would qualify the child for Medicaid.

5. Coverage that is the same as defined by the grandfathered existing comprehensive state-based coverage offered in Florida, New York and Pennsylvania -- In the CHIP regulations, CMS lists as one Secretary-approved option use of the grandfathered benefits currently offered in one of these three states whose comprehensive benefit package was cited by Title XXI as having sufficient coverage to meet the requirements for CHIP. The benefits in each state are summarized as follows:

    a. *Florida* -- The Healthy Kids benefit package is the benefit package that existed prior to CHIP that was cited in the Title XXI legislation as acceptable child health coverage. This benefit package includes a full range of inpatient and outpatient services. Limitations are placed on psychiatric, rehabilitation and physical therapy inpatient admissions; alcohol and drug services; chiropractic services; podiatry services; outpatient rehabilitation services; and, durable medical equipment and remedial devices;

    b. *New York* -- The benefit package for enrollees in the separate child health program is the comprehensive benefit package offered under the State-funded CHPlus program that was in effect prior to the establishment of the State CHIP, plus several added benefits, including durable medical equipment, inpatient and outpatient mental health, speech therapies, and some non-prescription medications. The fourth state-plan amendment (SPA) submitted by NY added non-airborne pre-hospital emergency medical services provided by an ambulance service, and the state's fifth SPA added a hospice benefit;

    c. *Pennsylvania* -- The benefit package is the PA CHIP benefit package that was implemented prior to SCHIP. Services include: inpatient hospitalization; outpatient services; physician services; surgical services; clinic services; prescription drugs; laboratory and radiological services; inpatient and outpatient mental health services; inpatient and outpatient substance abuse services; durable medical equipment; home and community-based health care services; nursing care services; dental services; case management; physical, occupational, and speech therapy; hospice care; and ambulance services when medically necessary.

6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison -- There is no evidence of a state seeking or receiving approval to offer CHIP coverage pursuant to this option; or,

7. Other -- There are four states with Secretary-approved "other" benefit plans that are not modeled on Medicaid or a benchmark plan such as the state employee plan:

    a. *Massachusetts* -- Children enrolled in the State's SCHIP Medicaid expansion program receive the Medicaid benefit package. What Massachusetts refers to as "direct coverage" enrollees receive the benchmark benefits coverage (HMO with the largest commercial enrollment in the State). MassHealth Healthy Start enrollees receive the Basic Benefit Level, as approved by the Secretary under the Massachusetts 1115 section Medicaid demonstration project;

    b. *Oregon* -- The separate child health program offers Secretary-approved coverage that is the same as coverage offered under the State's Medicaid program. The State's benefit package is based on the Oregon Health Plan Prioritized List of Health Services, a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration waiver for its entire Medicaid population. Medically necessary services are defined in the Prioritized List;

    c. *Texas* -- According to the NASHP survey, Texas offers a Secretary-approved benefits plan with a basic set of health care benefits focused on primary health and that contain the cost of the benefit package. The State offers a three-tiered dental benefit. Each tier of dental benefits includes preventive services up to $250. The limit on the amount of therapeutic services available varies (ranging from $280 to $565) depending upon when an individual re-enrolls in the program at the end of a 12-month enrollment period; and,

    d. *Wyoming* -- Secretary-approved basic benefits as in Wyoming statute, and as determined by a health benefits committee appointed by the Governor. Families at or below 200 percent of the FPL have comprehensive dental and vision services. Families above 200 percent of the FPL receive preventative dental services with an annual limit of $150, and do not receive vision services. There is a $200,000 annual limit on benefits and a $1,000,000 lifetime limit on benefits.

Cost-sharing in Other State CHIP Programs

When states consider reductions in CHIP program costs, most states have reduced eligibility or increased family cost-sharing in the form of higher premiums or copayments. There is so far no evidence of major benefit shifts or benefit eliminations in CHIP programs.

Cost-sharing is a common feature of private health coverage around the country and a major element of difference among the numerous health coverage options available to purchasers. However, in the CHIP program, federal law sets specific maximum cost-sharing limits in recognition of the low incomes of families and children eligible for CHIP programs. CHIP cost-sharing can be in the form of monthly premiums; deductibles, an amount that families must pay before coverage begins; copayments at the time of service; or a combination of the two.

When states have faced fiscal and economic challenges, CHIP enrollee cost-sharing has been one area of cost-savings through increases in the out-of-pocket obligations for the families of children enrolled. For example, in 2009, 15 states made changes to reduce CHIP coverage, including California, and 14 of those increased monthly premiums.[15]

According to a December 2009 survey of Medicaid and CHIP programs conducted by the Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission), 34 states impose premiums or an enrollment fee in their children's health coverage programs, and nine states, including California, charge premiums to families with incomes below 150% FPL.[16] Table 10 below shows the range of premiums in states that have premiums and cost-sharing for CHIP programs as reported by the Kaiser Commission.

Table 10
Range of CHIP Premiums in States, 2009
By Family Income (Two Children)
Percent of Federal Poverty Level

Poverty Level	Premium Range
101%	$8-$15
151%	$10-$61
201%	$15-$115
250%	$30-$183
300%	$20-172
350%	$90-$152

Source: Kaiser Commission, December 2009.

In states with premiums, the median premium for two children in a family of three earning 200% percent of FPL ($36,620 per year for a family of three in 2009)[17] is $480 per year, $40 per month, or 1.3 percent of family income. Twelve states impose "lock-out" periods on children in families that do not pay the required premium, preventing such children from re-entering the program for a specific period of time after being disenrolled. Twenty states require copayments for non-preventive physician visits, emergency room care, and/or in-patient hospital care for children in families with income at 200% FPL; and, 24 states require a copayment for prescription drugs for children.

Conclusion

Kelch Associates partnered with Mercer at the request of MRMIB and with the support of CHCF to identify potential areas of cost savings in HFP benefits. Kelch Associates identified benefit options under federal law and compared HFP to existing benefit options. Project consultants presented options and categories of options to MRMIB and, at their request, conducted further analyses of selected options.

Mercer conducted actuarial and fiscal analyses to estimate the potential for alternative benefit designs that would comply with federal actuarial equivalence standards. Mercer found that California could change benefits and meet federal actuarial standards primarily because of the cost sharing levels in HFP

that are constrained by the federal annual 5% of income cap on family cost sharing. This report summarizes the Kelch Associates research on federal benefit options, other state programs and comparison of HFP to other options. There could be other benefit options developed and analyzed but this report provides illustrative analyses to guide MRMIB and policymakers in evaluating HFP benefit design changes going forward.

Specifically, this project identified and analyzed three categories of potential HFP savings: reduction of HFP benefits to the minimum level required in federal law, imposition of annual benefit caps, and increases in HFP family cost sharing. Table 11 summarizes the potential cost savings identified for each category and shows that overall implementing all three options would save $16.2 million General Fund but would also result in a loss of $30.1 million federal funds.

Table 11
Summary of Mercer Findings
(Dollars in Thousands)

	Estimated 2010-11 HFP Savings		
Benefit Design Change	**General Fund**	**Federal Funds**	**Total Funds**
Eliminate coverage for benefits not mandated in federal law	$3,900	$7,100	$11,000
$200K annual benefit maximum	$7,000	$13,000	$20,000
Increase physician copayments from $10 to $15 for Categories B & C	$5,400	$9,900	$15,300
Total Estimated Savings Potential	**$16,200**	**$30,100**	**$46,300**

At the May 27, 2010 MRMIB meeting, Board members reiterated the changing environment since this project was initiated, including the passage of federal health care reform, and expressed the sense of the Board not to move forward at this time to implement any of the options analyzed.

Decision Framework for Evaluating HFP Benefit Options

At the beginning of this project, MRMIB requested that Kelch Associates develop and recommend a decision framework for evaluating the various coverage and benefit options available under federal law. Kelch Associates recommends that the State take into account the issues and considerations outlined in Table 12 when evaluating HFP benefit options.

Table 12 Decision Framework for Evaluating HFP Benefit Changes	
Category	**Impacts Analysis**
Subscriber Impacts	How will the proposed benefit/program change affect HFP subscribers? Subscriber costs? Will cost increases or benefit changes impact enrollment? Quality of life impacts? Choice of and access to providers?
Federal Authority	Is the benefit/program change allowable under federal law? Is federal approval required? What is the likely result of seeking federal approval?
Implementation Costs	What staff or administrative costs will result from the change? State staffing costs? Health plan or provider administrative costs? Will external experts or resources be needed to implement the proposed changes? Do the costs of initial or ongoing implementation outweigh any potential for savings? Short versus long term?
Implementation Timeline	How long will it take to accomplish the benefit/program change? Anticipated timing for any required federal approvals or state statutory/regulatory changes? What will be the time horizon for savings? Can the benefit/program change be implemented to achieve and capture savings in the near term? Budget year 2010-11?
Unintended Costs or Consequences	Will the benefit/program change result in unintended costs in other areas that reduce or eliminate the savings potential? For example, will elimination of a specific primary care service or benefit result in increased utilization of other services such as increased hospital or emergency room use?
Network or Provider Impacts	How will the benefit/program change affect health plan participation in the program? How will the benefit/program change affect provider participation?
History	Has the benefit/program change been previously proposed and considered? What was the outcome or experience?

As a concluding analysis, Table 13 evaluates the three options using the framework above as recommended by Kelch Associates.

Table 13 Framework Evaluation of HFP Benefit Changes			
Category	**Elimination of benefits not required in federal law**	**Annual benefit caps**	**Subscriber Cost sharing increases**
Subscriber impacts	Mercer modeled the elimination of home health (including hospice), DME and supplies, physical and occupational therapy, and speech therapy. In the absence of these benefits which often are supportive to recovery following illness or surgery, children could experience delayed recuperation, or short or long term disabilities from lack of follow-up therapies.	Mercer modeled annual benefit limits of $200,000 and $50,000. Children whose health care costs would reach the limit, who were not eligible for other public programs such as CCS, could experience disruptions in care as well as access challenges to the extent that low and moderate income HFP families would be unable to pay out-of-pocket for the continuing costs of services.	Mercer modeled the premium increases proposed in the Governor's January 2010-11 Budget and increases in copayments for specific services. Premium increases can cause subscribers to drop coverage or discourage new families from signing up for coverage. Service-related cost-sharing can cause subscribers to delay or not seek treatment which could result in worsening health conditions that become more expensive to treat.
Federal authority	1) The project found that California could eliminate the benefits above and still comply with federal standards for a benchmark-equivalent plan. 2) Would require a state plan amendment to be filed with CMS. 3) Unclear if would be allowed given state CHIP maintenance of effort in federal health reform.	1) Would require a state plan amendment to be filed with CMS. 2) May be precluded under PPACA which prohibits "unreasonable" annual limits and may not be allowed if impacts state CHIP maintenance of effort. It is not clear as of this writing how the MOE and the restrictions on annual benefit limits would be implemented in CHIP.	Mercer found that there could be increases in HFP cost sharing above current levels without exceeding the federal 5% of income limit for families. Cost sharing approaching the 5% could increase administrative costs for MRMIB and participating health plans if potential federal requirements to notify families of the their potential maximum costs are imposed.
Implementation costs	1) Contracting plans would have to file benefit changes as material modifications with the state Department of Managed Health Care (DMHC). 2) MRMIB would have regulation costs, costs related to brochure and web site presentations of benefits. 3) The benefit changes would require a state law change to exempt HFP plans licensed under Knox-Keene.	1) Contracting plans would have to file benefit changes with state DMHC. 2) MRMIB would have regulation costs, costs related to brochure and web site presentations of benefits. 3) The benefit changes would require a state law change to exempt HFP plans licensed under Knox-Keene.	1) MRMIB could incur staff and administrative costs related to regulations, and for changes to HFP communication documents and web site presentations of benefits. 2) MRMIB could incur significant increased administrative costs to the extent cost sharing increases necessitate that California comply with federal rules aimed at ensuring that no family exceeds the federal 5% out-of-pocket limit. 3) Potential increased related to tracking subscriber cost sharing could discourage plan participation.

Table 13 Framework Evaluation of HFP Benefit Changes			
Category	**Elimination of benefits not required in federal law**	**Annual benefit caps**	**Subscriber Cost sharing increases**
Implementation timeline	Would require submission of a State Plan Amendment (SPA) to the federal CMS, with approval timelines ranging from 90 days to as much as one year. Change could be precluded by state CHIP maintenance of effort requirements in federal health care reform legislation.	Would require submission of a SPA to the federal CMS, with approval timelines ranging from 90 days to as much as one year. Change could be precluded by state CHIP maintenance of effort requirements in federal health care reform legislation.	Would require submission of a SPA to the federal CMS, with approval timelines ranging from 90 days to as much as one year. Change could be precluded by state CHIP maintenance of effort requirements in federal health care reform legislation.
Unintended costs or consequences	There would be minimal unintended costs, other than direct subscriber impacts, from the elimination of the benefits not required in federal law.	There could be a change in the risk mix of children in HFP. Limited benefits could discourage families with healthy children from enrolling in HFP if they can obtain private coverage with better benefits at a reasonable price.	Mercer found that increasing copayments for office visits from $10 to $15 would result in cost savings but would also likely cause a decrease in overall utilization of physician services, and potential increases in emergency and inpatient services that could reduce the potential savings from just over 4% to 2-3%.
Network or provider impact	Providers of the eliminated services would be excluded from participation in HFP. Knox-Keene licensed plans could only participate if they were exempted from Knox-Keene basic benefit requirements.	Providers and health plans could experience significant uncompensated care costs to the extent that they choose to continue providing services to children that reach the annual limit. Higher costs could discourage plan and provider participation in HFP.	1) Increased copayments at the time of service can mean an effective reduction in provider payments if providers are unable to collect from low-income patients, potentially affecting provider willingness to participate in the program. 2) Plans could face increased provider payment costs to the extent they have to make up provider reductions that occur in order to meet provider access standards and needs.
History	No.	No.	Yes. Increased premiums in 2008-09 and 2009-10 budget. The 2010-11 May Revision proposed further subscriber cost sharing for both premiums and copayments. Impact? (Ernesto)

[1] Centers for Medical and Medicaid Services. *Letter to State Health Officials: SHO 09-014: CHIPRA #9*. November 4, 2009..
[2] Congressional Research Service. *State Children's Health Insurance Program: A Brief Overview*. March 18, 2009.
[3] 42 Code of Federal Regulations, Chapter IV, Subpart 457, Section 457.555.
[4] Ibid.
[5] Kaiser has higher enrollment in both the CalPERS and FEHBP program benefit plans but this is the HMO benefit plan with the highest commercial enrollment.
[6] *Critical Issues in Health Reform: Actuarial Equivalence. American Academy of Actuaries*. May 2009. Obtained online at: www.actuary.org/pdf/health/equivalence_may09.pdf
[7] Ibid.
[8] Hess et. al. *Charting CHIP IV: An Analysis of the Fourth Comprehensive Survey of State Children's Health Insurance Programs.* National Academy for State Health Policy (forthcoming).
[9] Mercer Human Resources Consulting. *Navigating the Pharmacy Benefits Marketplace. Prepared for the California HealthCare Foundation*. January 2003.
[10] Ibid.
[11] State plans and state plan amendments, along with a state plan fact sheet which summarizes the main features of each State's CHIP program, are posted on the CMS web site and can be obtained online at: www.cms.hhs.gov/NationalCHIPPolicy/StatePlan/
[12] There is some inconsistency between the NASHP and CMS data sources regarding CHIP benefit designs. Based on review of the data and discussions with NASHP and CMS, the differences most likely reflect different time periods or could also reflect the distinctions states might make between the technical terminology required for submission of state plans to CMS and the use of common terms at the state policy level. For example, a state that has submitted a "benchmark equivalent" plan based on state employee coverage for CMS approval might refer to the type of coverage in the NASHP survey as "state employee coverage." Some states did not respond to the NASHP survey and for those states Kelch Associates relied on the CMS fact sheets. Kelch Associates did not review each state CHIP plan and all of the state plan amendments for this project.
[13] Center for Medicare and Medicaid Services. *Children's Health Insurance Plan Activity as of April 23, 2010*. Obtained online at http://www.cms.gov/LowCostHealthInsFamChild/downloads/CHIPStatePlanActivityMap.pdf
[14] Herz, EJ, Peterson, CL, Baumrucker, EP. *State Children's Health Insurance Program (CHIP): A Brief Overview. Congressional Research Service*. March 18, 2009.
[15] Cohen Ross, D., Jarlenski M., Artiga S. and Marks C. *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009.* Kaiser Commission on Medicaid and the Uninsured. December 2009. Obtained online at: www.kff.org/medicaid/upload/8028.pdf
[16] Ibid.
[17] Department of Health and Human Services. 2009 poverty guidelines remain in effect until at least May 31, 2010 and can be obtained online at http://aspe.hhs.gov/poverty/index.shtml